Role Perception of Anganwadi Workers Towards the Disabled Children

By

Sumathi A.

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TO MY BELOVED FAMILY

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I INTRODUCTION

"It is not arms, legs, eyes or ears
but spirit that makes a man and he
be judged for what he can do rather
than what he is unable to do"

- Helen Keller

Disability conditions are found among the children everywhere in the world. Global estimation have indicated that nearly ten per cent of the world's population are either physically or mentally handicapped. By 21st century, there will be more than 600 million disabled in the world. According to World Health Organisation about 50 crores of people are handicapped. Among them 8 crores suffer from trauma injury, 10 crores suffer from malnutrition, another 10 crores come under congeital diseases and 4 crores suffer from functional psychiatric disturbances etc. The problem of disability thus assumed major dimensions throughout the world in recent times. The disabled in India are estimated to be seven per cent of the total population (Chandrashekaran, 1989).

In the recent years more and more awareness about the childhood disability and its social and economic consequences has been created among the planners as well as in the general public. The declaration of 1981 as the year of disabled and more recently launching of IMPACT - an action oriented project to combact the problem of disability are reflective of the concern for practical solutions of the problem of disability (NIPCCD, 1983; Social Welfare, 1990).

Children with major disabilities may not function completely within the normal range across a number of behavioral domains but there are data to suggest that such disabled children can be assisted in becoming more adaptive and independent. It is also well recognised that 70 per cent of the impairments are preventable, caused, as there are, by widespread malnutrition, faulty child rearing practices, inadequate perinatal care, communicable diseases, unhealthy environments, accidents etc. Further in a large number of cases impairments can be cured or their disabiling effect considerably reduced with timely detection and intervention (Ray, 1989).

It is feared that the country will have population of 30 million disabled by the turn of the century and therefore vigorous effects are needed to arrest their growing number. However to screen all children all over the country for identification of possible handicapping conditions in them may be an ideal proposal, but certainly not possible in practice (NIPCCD, 1989).

It is now widely thought that a comprehensive and coordinated approach to the rehabilitation of the disabled should be adopted. The basic thrust of efforts should strengthen the family and community in getting to know how best the disabled could be helped. Hence, linked with this there is a need to adopt appropriate methodology, economically sound and effective enough to identify as many handicapped children as possible at an early stage. For this purpose, the Anganwadi workers of the ICDS scheme can be advantageously utilised (Chowdry, 1990).

The Anganwadi workers come in to contact with mothers and are associated with immunisation programmes. They can be trained to identify impairments and disabilities in children and train them to become self reliant.They can also be trainedto

screen for developmental delays. The Anganwadi workers can be motivated to involve the parents and train them to help in training their disabled children at home. Subsequently they can help them in integrating the child in primary school education programmes (NIPCCD, 1986; Sharma, 1987).

Many National Institutes have established beyond doubt that a grass root workers like Anganwadi workers is able to detect all major childhood disabilities. It is also suggested that the future efforts to train Anganwadi workers in detection of disabilities should not confine to one single disability. She should be informed about all the disabilities. By one survey she can collect information about all the disabilities (Baru, 1985).

As early detection of disabilities has also been included in their responsibilities, it is necessary to find out how far they have perceived their role in carrying out this responsibility. It is hoped that this study would throw light upon the feasibility of strengthening the input in the curriculum of Anganwadi workers to enable them to identify the at-

risk and the disabled children in Anganwadies and provide appropriate care and services to the disabled children. Hence, this study has been taken up with the objective of finding out the role perception of Anganwadi workers towards the disabled children.

II REVIEW OF LITERATURE

Literature pertaining to the study on "Role perception of Anganwadi workers towards the disabled children" is dealt under the following aspects.

A. Profiles of the Disabled Children

B. Strategies for Prevention of Disabilities

C. Role of the ICDS Anganwadi Workers in Prevention, Early Detection and Care of the Child.

D. Intervention Programmes for the Disabled Children.

A. Profiles of the Disabled Children:

Disabled is a status of helplessness something which falls short of the norm or standard viz. 'Physical fitness' (Ramamani, 1988). According to World Health Organisation (1981) disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

In India it is estimated that approximately 30 per cent of our population is affected by one

disability or the other (U.N. Expert Group Report). The provisional figures of 1981 census indicate that the country has a total of 1,118,948 disabled persons, of which 42.8 per cent are blind, 32.5 per cent are cripped and 24.7 per cent are dumb. While 86.7 per cent of these disabled persons live in rural parts of India, the rest 13.3 per cent are distributed over the Urban pockets of the country. Of those disabled in rural areas 43.8 per cent are blind, 31.4 per cent are crippled and the remaining 24.8 per cent are dumb. The percentages of blind, crippled and dumb among the urban disabled are 36.3, 38.4 and 25.3 respectively (Sathyanarayana and Ranga Rao, 1983). The following table illustrates the population and disabled persons for India by States.

TABLE I

POPULATION AND DISABLED PERSONS FOR INDIA BY STATES

States	Population 1980 (in 1000s)	Disabled persons 1981	Disability rate per 1000 population
Andhra Pradesh	50,603	100,552	2.0
Assam	19,794	N.A	-
Bihar	67,029	98,735	1.5
Gujarat	32,396	68,399	2.1
Haryana	12,226	15,843	1.3
Himachal Pradesh	4,150	10,714	2.6
Jammu and Kashmir	5,836	13,795	2.4
Karnataka	34,959	54,730	1.6
Kerala	25,519	31,053	1.2
Meghalaya	1,289	2,676	2.1
Madhya Pradesh	51,940	101,873	2.0
Maharashtra	59,806	82,392	1.4
Manipur	1,421	2,161	1.5
Nagaland	N.A.	2,167	-
Orissa	26,553	61,298	2.3
Punjab	15,788	19,328	1.2
Rajasthan	32,647	80,043	2.5
Sikkim	N.A	2,483	-
Tamil Nadu	46,725	87,431	1.9
Tripura	2,045	4,143	2.0
Uttar Pradesh	103,900	164,556	1.6
West Bengal	54,781	100,955	1.8
Union Territories	8,828	12,990	1.5
Total India	659,387	1,118,948	1.7

Table I gives the information on the disability rates calculated for all States in India based on the estimated 1980 population and the disabled population of 1981 for each state. However, it is pertinent to note that despite the significantly lower rates in 1981, the emerging inter-state pattern is more or less similar to the pattern given by the earlier censuses and sample surveys. Accordingly we notice a disability rate of 1.7 per thousand population at all India level.

Table II gives the proportional distribution of disabled persons among the states revealing the volume and intensity of the problems of disability.

TABLE II

VOLUME OF DISABILITY BY STATE, BY TYPE OF DISABILITY AND BY RURAL URBAN RESIDENCE

State	Percentage of disabled persons bystate	percentage Disabled to the total of each state			Number of Rural disabled per 1000 urban Disabled
		Blind	Crippled	Dumb	
Andhra Pradesh	9.0	39.7	29.9	30.4	8,165
Assam	-	-	-	-	-
Bihar	8.8	40.2	35.7	24.1	15,360
Gujarat	6.1	34.3	47.3	18.4	3,782
Haryana	1.4	48.3	30,5	21.2	6,098
Himachal Pradesh	0.9	36.6	25.2	38.2	28,927
Jammu & Kashmir	1.2	28.2	36.4	35.4	8,136
Karnataka	4.9	31.1	34.4	32.2	4,829
Kerala	2.8	26.3	38.8	34.9	4,696
Madhya Pradesh	9.1	52.5	33.6	13.9	10,006
Maharashtra	7.4	44.9	32.0	23.1	4,287
Manipur	0,2	28.6	32.4	39.0	5,772
Meghalaya	0.2	41.7	28.0	30.3	16,377
Nagaland	0.3	18.6	20.5	60.9	40,059
Orissa	5,5	45.1	32.5	22.4	13,781
Punjab	1.7	46.8	33.1	20.1	5,688
Rajasthan	7.2	58.0	26.9	15.1	7,704
Sikkim	0,2	7.3	14.5	78.2	24,598
Tamilnadu	7.8	33.4	34.4	32.2	3,097
Trupura	0.4	36.7	36.1	27.2	12,997
Uttar Pradesh	14.7	56.9	25.2	17.9	10,284
West Bengal	9.Ø	28.9	33.8	37.3	5,706
Union Territories	1.2	33.4	33.1	33.5	1,201

Source: Office of Registrar General, Government of India

It is noticed that Uttar Pradesh has the maximum number of disabled persons in India. Next in order comes, Madhya Pradesh (9.1%), West Bengal (9.0%), Andhra Pradesh (9.0%) Bihar (8.8%), Tamil Nadu (7.2%), Gujarat (6.1%) and Orissa (5.5%). In all other states the percentage of disabled persons is below 5 per cent. All north-eastern states like, Manipur, Meghalaya, Sikkim, Nagaland and Tripura have a contribution of each below 1.0 per cent for the reason that they have a small population. The same table shows the proportional distribution of blind, crippled and dumb (Sathyanarayana and Ranga Rao, 1983).

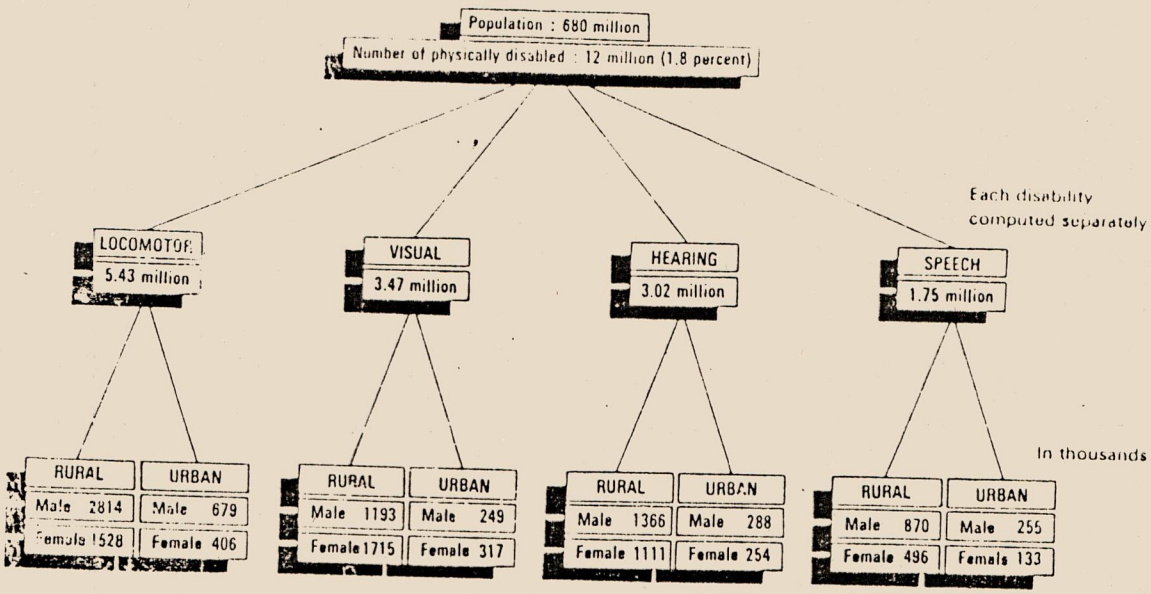
Between July and December 1981, the International year of Disabled persons, a national sample survey (36th round) was organised by the Government of India, to cover visual, hearing, speech and locomotor disabilities. Such a comprehensive enquiry was made for the first time and all districts in the country - except a few difficult to access - were not reached. Some 5409 sample villages and 3652 urban blocks were surveyed - to cover 81858 rural and 56452 urban households (Future, 1983).

A few highlights of the volumincus data on physical disabilities are also presented in Figure 1.



Disability in India

NUMBER OF THE DISABLED



Review of Literature

B. Strategies for Prevention of Disabilities:

Prevention means measures aimed at preventing the onset of mental, physical and sensory impairment (primary prevention) or preventing impairment when it has occured, from having negative physical, psychological and social consequences (kaurs et al., (1989).

Disability prevention is not limited to health sector interventions but alsoincludes all types of social, vocational, educational, legislative and other interventions. The best results will be achieved only if all these interventions are combined (World Health Organisation, 1981).

Ramamani (1988) describes the measures in the three levels of prevention of disability as follows:

First Level Prevention:

The term is more or less equivalent to "Primary

prevention". It includes measures aimed at reducing the occurence of impairment. For example, provision of safe water and sanitation facilities; vaccination against communicable diseases; health education of the public; the encouragement of proper child-rearing practices; improving nutrition; hygiene and physical fitness of the population; limiting the availability and use of alcohol; psychotropic to prevent cogenital disease; passing legislation to reduce the number of accidents; and to diminish occupational health hazards; effective control of the side effects of therapeutic drugs; education of the public aimed at reducing accidents; improving food distribution; improving the general level of education and preventing gross child neglect and abuse.

Second Level Prevention:

School level prevention includes what is usually termed as "secondary prevention", in addition, it involves social intervention and the prevention of additional impairments in people who already have one impairment e.g. preventing the appearance of psychological disturbances following a somatic condition.

Third Level Prevention:

Once a disability has occured and is found to be irreversible, measures can be taken to prevent its transition into handicap. These include provision of therapy such as that at present provided by physiotherapists, occupational therapists, speech therapists and psychologists training of the disabled in self care; provision of technical aids such as protheses or orthoses; provision of social and vocational training; training of specific groups (such as the blind and the deaf) to enable them to participate in social and community life; education of the public in order to improve community and family attitudes towards disabled persons; provision of education and suitable jobs for those with functional limitation; provision of suitable housing and transport to those with restricted self-care ability or mobility; and elimination of physical barriers. These measures are also used to reverse disability, but with an increased emphasis on additional psycho-social measures since the patient at this stage often lost his motivation to break away from a pattern of already established dependency.

Third level prevention includes "Teritory prevention" plus a wide range of social interventions (WHO, 1981).

There is some overlap in the definition of 'rehabilitation" and disability prevention especially with regard to third level prevention. These two approaches can be said to complement each other preventive techniques being used as the first efforts to reduce disability and rehabilitation and care becoming necessary when preventive measures fail and disability or handicap sets in, or when appropriate preventive measures and technology are lacking.

To mount a comprehensive community programme of prevention one should be aware of the type and range of procedure and practices available. If one focus on only primary and secondary measures, ten strategies are identified.

1. Immunization

This is the most effective tool in the prevention of infectious diseases. Active artificial immunization is the procedure by which we duplicate the favourable aspects of response to infection without the full consequences of the specific disease though there are immunizing agents (vaccines) for 25

disorders. In making the recommendation of the vaccines for routine use, several factors were considered.

1. The present day risk of the disease
2. The benefit to the individual and society in preventing the diseases
3. The efficacy, safety, cost and availability of the vaccine
4 The alternatives to vaccines in prevention of the diseases and
5. The special needs and characteristics of the group or individuals to be immunized (Perlman, 1981).

There are number of developing countries still procrastinating about routine immunization against infectious disease and continue to annually add many severely handicapped and disabled children and adults to their already over burdened population.

2. Genetic Counselling:

Hereditary factors play an important role in the development of a number of disabilities. It is estimated that 521 diseases results from an autosomal recessive mode of inheritance (Mokusick, 1980). These include the more commonly known diseases of

phenylketonuria (PKU) Tay-sachs diseases and hypothyrodism. About 50 defined syndromes have been found to be related to hereditary hearing loss (Illinosis, 1974).

In order to reduce the incidence of disabilities associated with genetic factors, genetic counselling is the recommended preventive measures. Genetic counselling has been defined as a communication process which deals with the human problems associated with the occurance, or the risk of occurance, of a genetic disorder in the family, this process involves an attempt by one or more appropriately trained persons to help the individual or family (1) comprehend the medical facts, including the diagnosis, the probable course of the disorder and the available management (2) appreciate the way heredity contributes to the disorder and the risk of recurrence in specified relatives (3) understand the options for dealing with riskof recurrence; (4) choose the course of action which seems appropriate to them in view of their risk and their family goals and act in accordance with that decision and (5) make the best possible

adjustment to the disorder in an affected member and /or to the risk of recurrrence of that disorder (Perlman, 1981).

3. Prenatal care

The important services needed during pregnancy include a through assesment of any special risks because of family history or past personal medical problems; physical examination and basic laboratory tests; aminocentesis where indicated; and medical conselling on nutrition. Smoking, alcohol use, exercises, sexual activity and family planning (Surgeon General's Report, 1979). In 1977, 74 percent of the population of pregnant women received prenatal care during the first 3 months of pregnancy of the remaining women, too many received care only during the last three months of pregnancy, one to two percent received no prenatal care and were at greatest risk.

Many of the problems women experience during pregnancy can be avoided, corrected or considerably reduced if quality prenatal care is received. For

example, 8 per cent of women at high risk of having a low birth weight infant can be identified by the physician during the first prenatal visit. Immediate steps can be taken to reduce the risk of developmental problems or perhaps death (Perlman, 1981).

4. Mass Screening and Early Identification:

The process of early identification and appropriate follow up assessment and treatment is an essential preventive strategy. Since, its purpose is to select individuals in the early stage of a disease or disorder, this strategy is technically referred to as secondary prevention.

Early and accurate identification of potentially handicapping conditions is one of the most important prevention strategies but unfortunately underused and underrated. Vision and hearing screening of school children is considered one of the best of the formal identification programmes. But it is far from universal for school age children and often poorly implemented (Illinosis, 1974). The early identification of sensory disorders should be a

priority if one wishes to provide effective and successful treatment and special educational programmes for the visualand hearing handicapped (Mausner et al., 1982).

5. Family Planning:

It is reported that of the more than 4 million pregnancies a year in this country, one million are terminated by legal abortion. Of the more than 3 million births, it has been determined that one-third are unplanned. These statistics imply that half of all pregnancies are unplanned and many are unwanted (Surgeon General's Report, 1979).

Unplanned pregnancies often lead to deterterious effects in the child, the mother and the family. It may affect the health of the child and the social well being of the mother. It has been observed that births which are planned are more likely to realize a higher health status and the infants become the recipients of quality parental love and support need for healthy physical and emotional development (Perlman, 1981).

Family Planning agencies usually recommended that families have no more than two children and only at maternal ages between 20 and 34. To control unwanted pregnancies, supportive counselling and sex education are provided (Maccoby & Nathan, 1980).

6. Proper Medical Care:

Wheather an individual is in touch with a private physician or a health care agency accessibility to a health care resource is essential in maintaining good health (Grent, 1989).

As a prevention strategy, it is good practice to encourage each individual to maintain a periodic contact with a health care provider who is aware of the patient's history and thereby can keep track of pertinent developments in the health care of the individual.

7. Public Education:

This refers to education of the community for knowledge about prevention. The objectives of public education are to develop a prevention oriented person who (1) has broad knowledge of prevention strategies

(2) is strongly motivated to move from the state of knowledge to action, behaving in ways which lead to and maintain good health (3) understands the political process and what is necessary to effectively influence key individuals and social institutions to practice prevention (Perlman, 1981).

Information about prevention should be disseminated as widely as possible at the local, state, national levels. The use of mass media (television, radio and the press) will play an important role of the campaign is systematic and continuous, if the exposure of the information to the public is appealing and receives priority status (that is prime time on radio, televisionand front page coverage in news papers) and if key individuals are associated with the campaign. In addition it has been found that face to face instructional programmes to promote positive health behaviour in the population (Maccoby, 1980). The intensive face to face instructional program for certain segments of the community would reinforce the concepts communicated by the media campaign.

8. Education in Preparation for Life:

This strategy refers to the introduction of information about prevention at all levels in the

school system with the purpose of preparing young people for a more healthy life, both physically and mentally. Through appropriate instructional units, teaching aids and observations, elementary and secondary school students, should obtain sufficient knowledge about health and the prevention of illness, injury and disability (Perlman, 1981).

Also curriculum units should include education for parenthood, preparation for the major transitions in life, (adolescence, adulthood, older adulthood, leaving home, getting married and so on) and preparation for the major crises in life (death of a loved one, birth of a child, financial difficulties, loss of a job, sexual problems and so on such information should be introduced in a manner and sequence which is appropriate for the age and maturity of the students. Christoplos and Vallecutte view education as the "essential means of prevention" and call for massive education programme to teach individuals to behave in ways that minimize the likelihood of their becoming disabled (Bich, 1980).

9. Environmental Quality Control:

Planning for the improvement and maintenance of

environmental quality the following priorities are recognized:

1. The protection of the community water supply for consumption, recreation and other appropriate purpose
2. The control of air pollution
3. Disposal of refuse and waste
4. Occupational health and safety
5. Noise pollution
6. Food and Milk control
7. Radiation protection
8. Control of toxic (Substances in buildings such as lead paint, asbestos in ceilings of schools etc)
9. Low cost housing (Kruse, 1985).
10. Social and Educational Programmes to improve the quality of life:

This strategy suggests the need for special programmes for individuals at certain transition stages in life, focussing primarily in the potential problems of adults. This purposes of the strategy is to provide assistance through education and counselling to individual facing the prospect or stressful and disappointing experiences.

C. Role of ICDS Anganwadi Workers in Prevention, Early detection and care of the child:

For every nine children born normal, the tenth is born with or acquires some mental, physical or sensory impairment. Only if these impairments are detected early, a lot can be done to help these children specially in terms of their home management and early treatment to prevent disability or deformity. Thus several cases of handicaps could be prevented from occuring (Habibullah, 1986).

Kamble (1990) remarks that the anganwadi workers is a local women looking after a population of 1000 is in an ideal position to play a very important role in this area. The Anganwadi workers who is carrying the sole load of Integrated services. The success of the ICDS largely depends upon the Anganwadi workers. Each Anganwadi centre is looked after by a Anganwadi worker and a helper.

The Anganwadi workers should be on the alert to identify childhood impairments at a very early stage. One of the way of identification is to check whether

the child reaches the different milestones of growth at the normal points of time of his age or not. However if these are delayed by more than 1 - 2 months, the Anganwadi worker should refer such a child to be sub-centre or the primary health centre. She should also refer these children, who are born with any visible defect or deformity (Sharma, 1987).

A handicapped child is a human being with feelings just like others, therefore, needs as much love, kindness and attention as other children. In fact a handicapped child requires little more love, care and attention as he may be slower and more dependent than a normal child. The Anganwadi worker should however allow the handicapped child to mix with normal children (Chowdhry, 1990).

In 1982, a course on visual impairment was conducted in Chakrata block of Uttar Pradesh and another on mental retardation was organised in Chikballur block in Karnataka. The results of these courses as have proved that Anganwadi workers not withstanding their educational and other handicaps can detect disabilities provided they are given

adequate orientation and guidelines. The third course in this series, covered all the main disabilities including hearing and speech handicaps, visual impairment, orthopaedic handicaps and mental retardation. The course was conducted at the block level. In the first phase, conducted at Tughlakabad, thirty three Anganwadi workers and five supervisors of Mehrauli ICDS block in Delhi, were oriented and given the specific guidelines by medical experts. In the second phase, the cases of disabilities among children identified by the Anganwadi workers would be examined by medical experts to determine whether they they have been currently identified (NIPCCD, 1983).

The phase II of the orientation course for Anganwadi workers of Mehrauli ICDS block on early detection and prevention of childhood disabilities was conducted at primary health centre in 1983. The follow up of the phase 1, 33 Anganwadi workers were oriented and given specific guidelines for early detection of disabilities. In the phase II, 33 Anganwadi workers brought 283 cases detected by them as having visual, speech, hearing impairment, mental

retardation and orthopaedic handicaps. These cases were examined by a team of doctors who assessed them with a view to determining the correctness of detection and to guide the anganwadi workers in relation to appropriate referal services agencies. In most of the cases the Anganwadi workers had successfully detected disabilities after a short orientation of one week (NIPCCD, 1983).

The project undertaken by the Institute's Southern Regional Centre at Chickballur block in Karnataka, Anganwadi workers were required to survey the villages, identify mentally retarded cases and bring them for check-up during phase II. The Anganwadi workers brought 30 cases of suspected mental retardation. They were examined by medical experts. Almost all the cases brought by 34 trainess were found to be correctly identified (NIPCCD, 1982).

Anganwadi workers have proved that it is possible to detect visual impairment among pre-school children with little orientation and that it does not require higher education orientation course organised

by NIPCCD in Chakrata ICDS block. Thirty eight cases of refractive errors, vitamin A deficiency, cataract corneal opacity, trachoma and chroniciritis, eye infection were detected by Anganwadi workers. The ophthalmalogists examined these cases and found that all of them had been correctly identified by the 32 participants of an orientation course held in primary health centre, chakrata. This exercise also helped in parents education who had accompanied their children and who were examined by medical experts. This programme will be further followed up by the primary health centre, Chakrata and the National Institute of visually handicapped, Dehradun (NIPCCD, 1982).

D. Intervention Programmes for the Disabled Children:

It is by how well recognized that about 70 per cent of the impairments are preventable, caused as these are by widespread malnutrition, faulty child rearing practices, inadequateperinatal care, communicable diseases, unhealthy environments,

accidents etc. Further, in a large number of cases, impairments can be cured or their disabling effect considerably reduced with timely detection and intervention (Ray, 1989).

Children suspected of delayed or problematic development can often benefit from the specially designed activities to stimulate the areas of weakness. The effectiveness of an early intervention, for actual or potential developmental disorder is the milestone on which rests the diagnosis (Sharma, 1988).

Hayden and Pious (1979) exhorts that prevention is simply never too early to intervene and from the data base use it seems clear, that urgently needed interventions should occur long before a child is born. Once a child has arriving, the work necessarily shifts into amelioration away from prevention always a second choice for intervention beginning at birth is not too soon (Dutta, 1988).

The early intervention programmes first started

in USA by the Bureau of Education for the Handicapped (BEH) in 1969. Originally 24 programmes were developed for handicapped children from birth to age 8 in the year 1969 and subsequently they grew to 200 in 1977. In general, these and other promising programmes are built in one of the three models: a home-based programme, centre based programme or a programme that combines home and centre as settings for intervention (Heward and Ortanskay, 1980).

Need for Early Intervention Programme:

The stage at which a disability or the possibility of it is detected is crucial to the timely intervention for prevention of further aggravation or total cure. Early detection would certainly help timely intervention and management of disabilities with a view to minimize their ill-effects on the development of the child (Mehta, 1983).

The immediate attention should be paid to detect the deformity to avoid complication. The neurro disabilities in children, specially the subtle ones

if not detected early add to the problem later like behavioural and learning problems, attention deficit, minimal cerebral dysfunctioning, speech and language disorders and even resulting in mental retardation (NIPCCD, 1984).

The initial goal of the remedial education was to obtain a more normal rate of development. When the intervention is started late, it often turns out to be an impossible task to help the child cope with the increasing sensitivity to his difficulties and frustration leading to loss of confidence and behaviour problems. It is very important to involve the child's parents as well as the teachers in the intervention programme (NIPCCD, 1984).

There is a strong need for providing services for early detection and intervention but these services at present are woefully lacking. One of the possible ways of providing such services could be through existing net work of various services, institutions and functionaries working with children in the community under programmes of education

health, nutrition and child welfare in general these functionaries include representatives of local institutions like Mahila Mandals, Day Care workers, Community Health Volunteers and other extension functionaries (Ramamani, 1988).

Three models of intervention programmes:

(1) Home-Based Intervention:

As the name suggests, a home-based programme depends on the training and cooperation of the child's parents. The parents assume the responsibility as the primary care givers and teachers for their handicapped child. The trainer or home adviser is a specially trained professional who visits the home regularly to guide the parents, acts as a consultant, evaluates the success of the intervention and makes regular assessments of the child's progress. He may visit as frequently as several times a week but less than a few times a month. In some cases, he may convey the results of his in-home evaluations back to other professionals who make recommendations for changes in the programme. It is well accepted that prescriprive teaching of the handicapped child should be based on

the differential diagnosis by various professional like pediatricians, opthalmogist, audiologist, psychologists. Social workers speech and language therapists, physiotherapist and occupational therapist (Dutty, 1988).

The home-based programme has several advantages:

(1) The home is the child's natural environment and his parents are like the parents of normal children, his first teachers.

(2) Other family members like brothers, sisters and grand parents have more opportunity to interact with the child both for instruction and social contact.

(3) The learning activities and materials conducted in the home are more likely to be natural and appropriate than artificial contrued as inappropriate.

(4) It is often true that a well-trained parent can spend more time and give more attention of the child than the most adequately staffed centre or school.

(5) In addition, parents who are actively involved in helping their child to learn and develop have an advantage over parents who feel guilt, frustration or defeat at their inability to help their handicapped child.

(6) A home based programme allows a child to live at some which receiving an intensive education without totally distrupting the family life (Kaur et al., 1989).

(2) Centre Based Intervention:

In contrast with the home based programme, some easy intervention efforts are coordinated and carried out in a special educational setting outside home. The setting may be part of a hospital complex, a special day care centre or pre-school. In other cases the children may attend a specially designed developmental centre or training centre which offers a wide range of services for children with varying degree of handicaps. These centres offer the combined services of many professional from several fields (Mehta, 1983).

Most of the centre based programmes encourage social interaction and some try to integrate handicapped children with non-handicapped in day care or pre-school classes. In some cases, the child attends the centre each week day, some times for all or most of the day. In other cases the child may come less frequently through most centres expect to see the child at least once a week. Sometimes parents are given roles as class room aids or are encouraged to act as primary teachers. In a few programmes parents may spend time with professionals or take training while the child is in the centre. However almost all programmes recognize the critical need to involve the parents and they welcome parents in every aspect of the programme (Dutta, 1988).

Centre Based Programmes offer a number of advantages:

(1) One important benefit is the opportunity for a team of specialists from a different fields to observe the child and co-operate in the intervention and continued assessment. Many centres hold regular meetings about once a month at which all these

involved with the child sit down to discuss his progress or lack of it, his response to the strategies and new or revised objectives for him.

(2) The opportunity for contact with handicapped and non-handicapped peers makes the programme especially appealing.

(3) Parents involved in the centre programmes feel some relief at the support they get from professionals working with their child (Dutta, 1988).

(3) Combined Home Centre Programmes:

Perhaps the most common intervention model is the one which offers both centre based activities and home visits. Many programmes combine the intensive help from a variety of professionals in a centre with the continuous attention and sensitive care from parents at home (Dutta, 1988).

This programmes offers the advantages of both home based and centre based programmes. However, it would be best to view those choices - home, centre or combined programmes more alike than different. They

seem to have more in common than developmental curriculum a strong parent involvement, explicit goals and frequent assessment of progress, integration of handicapped children and staff team consisting of specialists (Kaur et al., 1989).

Some of the intervention programmes are impact can initiative for integrated intervention for disability prevention was launched in India in October 1983. Jointly by UNDP UNICEF & wlto to provide a new thrust to the prevention of avoidable disabilities in the country. Early detection and prevention of common disabilities will be main concern; information and education on prevention and care with strong community involvement will be emphasised; Co-operation of all health related sectors in disability prevention will be fostered (Social Welfare, 1990).

The National Programme for control of blindness has been included in the New 20-point programme. The object of the programme is to make a significant reduction in the incidence of blindness from the present level of 1.4 per cent to 0.3 per cent by 1999. The metropolitan slums and panchayat bodies have also been covered under this scheme. The programme envisages the development of various

services at periphral sector includes relief to the community in remote villages and strengthening of eye care services at primary levels (Swasth Hind, 1985).

The IYDP in 1981 highlighted the problem of disability and served to bring home to all important need for prevention of impairments through improved health care services aimed at reducing the incidence of child mortality and morbidity, along efforts directed at overall socio-economic development family was considered the most important target in the efforts to prevent disabilities and to ensure their early identification and management (NIPCCD, 1989).

The National Council of Educational Research and Training (NCERT) is implementing the PIED project incollaboration with the states. The project was launched by the Ministry of Human Resource Development (MHRD) with assistance from the UNICEF. The project envisage identification of disabled children and assessment of their disability with the help of experts. Their enrolement in school is later ensured. Toys & other equipment are also made available to the project schools (NIPCCD, 1990).

The Madras Regional Rehabilitation Training Centre (MRRTC) has developed solar chargers for hearing aids in collaboration with flerifron of Bangalore. UNICEF funds, the RRTC had standardised development of "language and articulations tests" in Tamil, Gujarati, Hindi, Kannada, Marathi, Bengali and Oriya. These tests help assess and programme treatment of speech impairment due to hearing loss, mental retardationn (Indian Express, 1991)

The Department of Science and Technology launched the "prevention of deafness scheme" in 1986. The three year scheme aimed at reducing hearing impairments in children through education on proper earcare. Early detection and management of upper respiratory tract infections can prevent hearing loss in a majority of the cases. This scheme also aims to reduce the incidence of deafness NIPCCD, 1988).

Salem has been chosen as one of the districts on All-India basis for a DANIDA assisted project on prevention of blindness and Rs.16 lakh has already

been released by the Union Government for this programme. This project aimed urging the ophthomologists to increase this year's target of 1.6 lakhs cataract operations this year to two lakhs (Swaminathan, 1991).

A symposium on child development organised at the Kalawatisaran Hospital under the ageis of Indian Academy of Paediatrics on 16 act, the participants stressed the need for early detection and remedial intervention to check the damage. The symposium was held in collaboration with the Association for the development of multiple handicapped child (NIPCCD, 1988).

The efforts made in the field of prevention, early detection, management of childhood disabilities and rehabilitation of the disabled in the last few years, both in government and voluntary sectors, it is hoped to reduce any future increase in disabled numbers.

Methodology

III METHODOLOGY

The methodology for the study on 'Role Perception of Anganwadi workers towards the disabled Children' included the following steps:

1. Selection of the Area
2. Selection of the Sample
3. Selection of the Tool
4. Collection of the Data
5. Analysis and Presentation of Data

1. Selection of the Area:

The four ICDS urban projects of Coimbatore City covering Selvapuram, Saibaba Colony, Pulliakulam and Singanallur were chosen for the study. The Anganwadies belonging to this project were the areas selected for the study.

2. Selection of the Sample:

The Anganwadi workers of these selected Anganwadies constituted the sample. Of all the four projects, the Anganwadi workers who had minimum one year of experience were selected for the study. The

The sample size consisted of 300 Anganwdiwadi workers. As these Anganwadi workers are the grass root levsel workers and in constanat touch with the community, especially with vulneralbe groups, it is easy for them to help in prevention, identification of the disabilities in children.

Table III shows the Distribution of selected sample

TABLE III

DISTRIBUTION OF SELECTED SAMPLE

ICDS Project	Sample Number
Selvapuram (Project I)	86
Saibaba Colony (Project II)	64
Puliakulam (Project III)	87
Singanallur (Project IV)	63

3. Selection of the Tool

The questionnaire was selected to collect the information, required for this study as this method is likely to be more accurate because the interviewer can clear up doubts of the informants about certain questions (Gupta, 1991). The questionnaire framed for this study included question on general information about Anganwadi workers and role perception of Anganwadi workers towards disabled children.

A pilot study was done with 20 sample drawn from all the four project areas, using the developed questionnnaire in order to find out the accuracy and adequacy of the questions.

4. Collection of the Data:

After securing permission from the Cell Officer of ICDS projects of Coimbatore District, a request was maade to the Child Development Project Officers of the urban projects of Coimbatore city to permit the invesstigator to meet the Anganwadi workers for gathering the information. Prior to distribution of questionnaire, the Anganwadi workers were met in groups and were given detailed information on the purpose of the study.

After establishing the rapport with the Anganwadi workers the questionnaire was given to the Anganwadi Workers with the request to fill in all the questions. The teachers were given two days time to furnish information requested and hand over it to the investigator.

4.. Analysis and Presentation of Data:

The data so callected was consolidated, analysed and discussed in the following chapter.

Results and Discussion

IV RESULTS AND DISCUSSION

The result of this study on "Role Perception of Anganwadi Workers Towards the Disabled Children" are presented under the following headings:

A. Background of Anganwadi Workers

B. Details of Disabled Children in the ICDS Project Area

C. Role of Anganwadi Workers in Identification and Care of the Disabled Children

D. Involvement of the Parents and the Role of Society in the Care of the Disabled Children

E. Government Programmes for Rehabilitation of the Disabled

A. Background of Anganwadi Workers:

This section features the educational level of the Anganwadi Workers, experience and details of the training of the Anganwadi Workers.

(i) Educational Level of the Anganwadi Workers:

Table IV focusses the educational level of the selected Anganwadi Workers.

TABLE IV

EDUCATIONAL LEVEL OF THE ANGANWADI WORKERS

S.No	Educational Level	No of AWWs N=300 %
1	High School (S.S.L.C)	84
2	Higher Secondary School	15
3	College	1

More than three fourths the number (84%) of Anganwadi workers had studied upto S.S.L.C, which is a basic requirement for being an Anganwadi worker. Fifteen per cent of the Anganwadi workers had finished higher secondary education, followed by one per cent who had completed their graduation.

The New Education Policy which is now being formulated in the country stresses. Early childhood care and education (ECCE). As a policy, only those who complete higher secondary level of education must be motivated to take up teacher job under the ECCE system in order to have important input in the strategy of Human Resource Development.

ii) Experience of the Anganwadi Workers

Table V highlights the experience of the selected Anganwadi Workers.

TABLE V

EXPERIANCE OF THE ANGANWADI WORKERS

S. No	Experience in Years	No.of AWWs N=300 %
1	Less than 2 years	9
2	3 - 5 years	6
3	6 - 8 years	15
4	9 - 11 years	68
5	12 years and above	2

Nine Per cent of the teachers were new and inexperienced having less than 2 years working experience in the Anganwadi. Those who had three to five years of experience were six per cent. Fifteen per cent of them had gained six to eight years of experience as Anganwadi workers. It is heartening to note that sixty eight per cent of the anganwadi workers had put in nine and eleven years of experience. Only two per cent of them had 12 years and above.

(iii) Training of the Anganwadi Workers:

Table VI shows the details of training of the Anganwadi Workers.

TABLE VI

DETAILS OF TRAINING OF THE ANGANWADI WORKERS

S.No	Details	No.of AWWs N=300	%	Duration of Training	No.of AWWs N=294	%
1	Trained	94		Orientation Training 3 months	91	
2	Untrained	6		Refresher Training		
				15 days	6	
				10 days	3	

It is encouraging to note that 94 per cent of the Anganwadi workers were trained and only 6 per cent of them were untrained. Ninety one per cent of the Anganwadi workers had undergone orientation training for three months. It is rather disapponting to note that only a few had undergone refresher training which is a basic requirements for the trainind teachers to become aware of the growing needs of the children and to promote efficacy of Anganwadi workers.

B. Details of Disabled Children in the ICDS Project Area:

This section includes prevalence of disabled children in the ICDS project area, causes, method of identification of disabled children by the Anganwadi workers in their community.

Out of 300 selected Anganwadi workers only 222 have expressed that they have disabled children in their community. Those Anganwadi workers could identify 300 disabled children from their community. One hundred and forty one Anganwadi workers had mentioned that a few children had been admitted in their Anganwadi.

(i) Causes for the Disability:

Table VII depicts the causes for the disability as expressed by the Anganwadi workers.

TABLE VII

CAUSES FOR THE DISABILITY

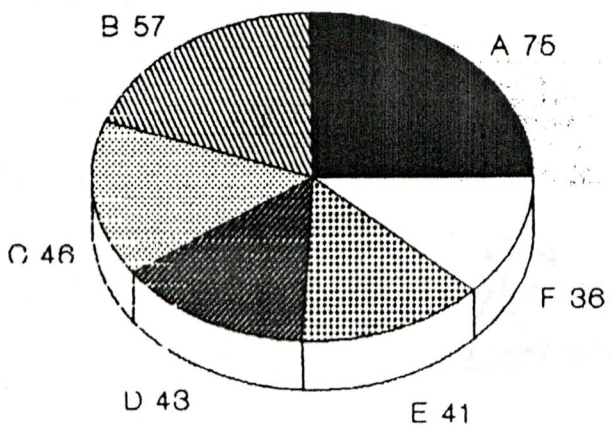
S.No	Causes	No.of AWWs N=300 %
1	Heredity	75
2	Infectious Diseases	57
3	Consuming Drugs during Pregnancy	46
4	Trauma	43
5	Consanganious Marriages	41
6	Early and late marriages	36

Three fourth of the selected Anganwadi workers were in opinion that the disability conditions occur due to heredity. Fifty seven per cent of the Anganwadi workers had indicated infectious diseases as the cause for the disability among children, followed by consuming drugs during pregnancy (46%), Trauma (43%) and consanganious marriages (41%), very early and late marriage was expressed by 36 per cent of the Anganwadi worker (Fig 2).

(ii) Type and Number of Disabled Children

Table VIII pictures the type and number of disabled children identified by the the Anganwadi workers in their community.

CAUSES FOR THE DISABILITY



A. Heredity
B. Infectious diseases
C. Consuming drugs during pregnancy
D. Trauma
E. Consanganious marriage
F. Early and late marriage

TABLE VIII

TYPE AND NUMBER OF DISABLED CHILDREN

S.No	Types of Disability	No.of Disabilities N = 300 %
1	Motor Disability	48
2	Mentally Retarded	21
3	Speech Disorder	21
4	Multiple Handicaps	5
5	Visually Impaired	3
6	Hearing Impaired	2

Forty eight per cent of the disabled children suffered from motor disability and similar per centage (21%) of children were mentally retarded and speech defective. Only every few were multiple handicaps (5%), visually impaired (3%) and hearing impaired (2%). The higher level of motor disability might be because of the reason that the anganwadi workers could identify the same easilycompared to other disabilities.

(III) Disabled Children in the Anganwadies:

A majority of Anganwadi workers (61%) reported that they admitted the disabled children in their Anganwadi, so as to improve their functioning by providing necessary care and guidance. The minority of anganwadi workers (39%) told that

since some children had joined in other schools, some were at home due to their severe disabilities.

On analysing the condition of the disabled children in anganwadis, the Anganwadi workers expressed that the disabled children in the Anganwadi were happy, when they were at the Anganwadi.

C. Role of Anganwadi Workers in Identification and Care of the Disabled Children:

This part covers the methods followed to identify disabled children by the Anganwadi workers, facilities needed in the Anganwadi, attention given by the Anganwadi workers, preventive measures taken by them, the referral services done by the Anganwadi workers, and educational facilities available for the disabled children.

(i) Methods of Identification of the Disabled children by the Anganwadi Workers:

Methods to identify disabilities among children as used by the Anganwadi workers are indicated in the Table IX.

TABLE IX

IDENTIFICATION OF DISABILITIES AMONG CHILDREN

S.NO	Ways of Identification	No.of AWWs N=222 %
1	Physical Appearance	75
2	Lack of Co-ordination	72
3	Voice Disorder	71
4	Hand and Leg Paralysis	61
5	Fails to Understand the speech and ask for repetition	57
6	Use of Gestures for Communication	43
7	Leg limbing	39
8	Delayed speech and language development	29
9	Lack of Concentration	16

Nearly three fourth of the selected Anganwadi Workers identified the disabled children by seeing the difference in their physical appearance (75%), lack of co-ordination in their movements (72%)and

voice disorder 71%) and hand and leg paralysis and fail to understand the speech and ask for repitions were expressed by 61 and 57 per cent of the Anganwadi workers respectively. Less than 50 per cent had mentioned use of gestures for communication (43%) leg limbing (39%) delayed speech and language development (29%) and lack of concentration (16%).

(ii) Facilities Available to Identify the Disabled Children

The following table pictures the facilities that were needed in the Anganwadis to identify the disabled children as expressed by the Anganwadi workers.

TABLE X

FACILITIES NEEDED IN THE ANGANWADIS

S.No	Facilities	No of AWWS N = 300	%
1	Special Equipments	48	
2	Finance	37	
3	Medical Service	36	

The additional facilities the Anganwadi Workers needed to identify the disabled children were special equipment (48%), finance (37%), medical service (36%). Thus the findings show the inadequate knowledge of Anganwadi workers to identify the disabled children and the need for short term intensive training in identification and assessment of the disabled children in their community.

(iii) Attention Given For Disabled Children:

Table XI highlights the attention given by the Anganwadi workers for the disabled children.

TABLE XI

ATTENTION GIVEN FOR THE DISABLED CHILDREN

S.No	Types of Disability	Attention Given	No.of AWWS N=222 %
1	Mentally retarded	Teaching by repetition , satisfy	51
		their basic needs	18
		Training them to meet the daily needs	18
2	Blind	Sense Training	38
		Mobility Training	17
3	Hearing Impaired	Sign language	64
4	Speech disorder	Speech training	42
		Lip reading	41
5	Motor Disability	Mobility training	27
		Meeting everyday need	11

Only a very few Anganwadi workers seem to have known the needs of special children. This is an alarming situation since handling of young disabled children requires speicific knowledge base and skills. This situation brings forth the additional input in the curriculum regarding the care of the disabled children in the training of Anganwadi workers.

(iv) Preventive Measures Undertaken by the Anganwadi Workers:

— Table XII indicates the knowledge of Anganwadi workers in prevention of disabilities among children.

TABLE XII

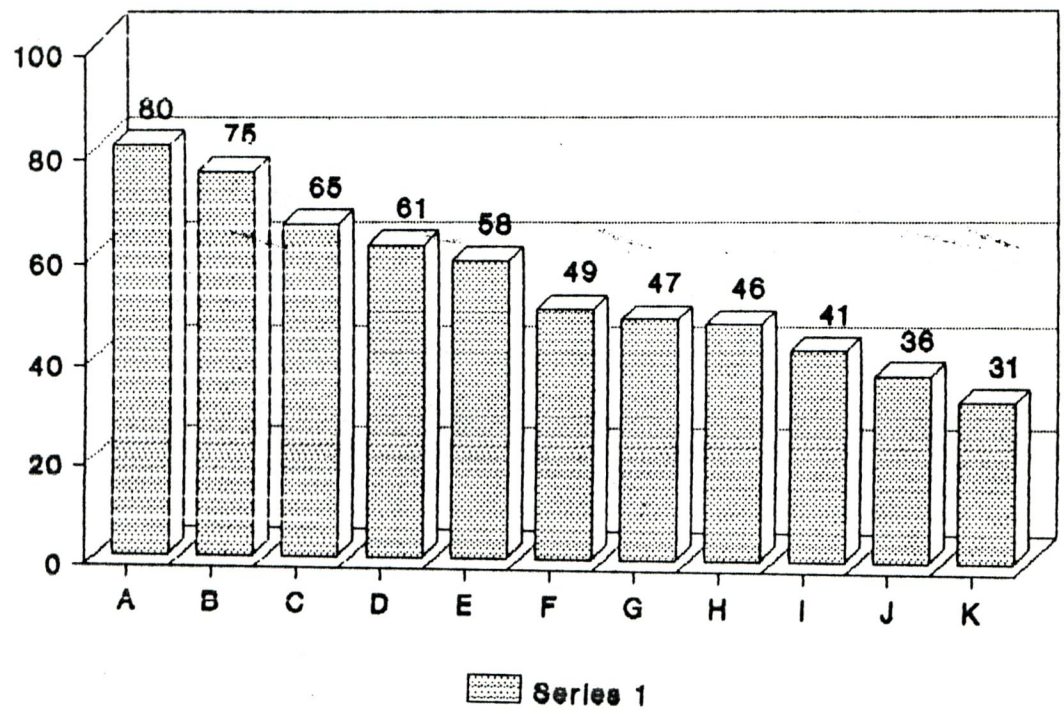
PREVENTIVE MEASURES UNDERTAKEN BY THE ANGANWADI WORKERS

S.No	Preventive Measures	No.of AWWs No=300 %
1	Immunisation for pregnant women	80
2	Immunisation for children	75
3	Provide Nutritious food for children	65
4	Provide Nutritious food for pregnant and lactating mothers	61
5	Medical check up for pregnant women	58
6	Health check up for children	49
7	Take vitamin A Iron rich tablets	47
8	Avoid using drugs during pregnancy women	46
9	Avoid marriages between close relation ship	41
10	Avoid Early and late marriage	36
11	Avoid taking x ray during pregnant period	31

Immunisation for pregnant women (80%) stood foremost as the prime preventive measures to avoid disability among children. Three fourths of the Anganwadi workers had indicated giving immunisation for the children followed by providing supplementary nutrition for the mothers (65%) and the children (61%) and health checkup for the pregnant women (58%). A considerable number of Anganwadi workers had pronounced health check up for children (49%), distribution of Vitamin A and iron rich tablets (47%), avoid using drugs (46%) and marriage between close relationship (4.1%), consequences of early and late marriages and taking x rays were indicated by less than 40 per cent of the Anganwadci workers (Fig. 3)

The importance of immunisation, nutritious foods and health check up for pregnant mothers and children to prevent disability were very popular among common populations as these were projected in the mass media. The Anganwadi workers need to be rechanged with vitality, alertness and enthusiam to acquire the knowledge on the preventive meansures in order to safe guard the future citizens.

PREVENTIVE MEASURES



A. Immunisation for pregnant women
B. Immunisation for children
C. Provide nutritious food for children
D. Provide nutritious food for pregnant and lactating mother
E. Medical check up for pregnant women
F. Health check up for children
G. Provide Vitamin A, Iron rich tablets
H. Avoid unnecessary drugs
I. Avoid consanganious marriages
J. Avoid Early and late marriage
K. Avoid taking X-rays during pregnancy period.

(v) Places where the Disabled Children are Referred:

Table XIII pictures the places where the disabled children are referred by the Anganwadi Workers.

TABLE XIII

PLACES WHERE THE DISABLED CHILDREN ARE REFERRED

S.No No=222	Name of the Place	No.of No=222,	AWWS %
1	Hospital	63	
2	Primary Health Centre	24	
3	Specialist	10	
4	Special Institution	3	

Sixty three per cent of the Anganwadi workers were doing referral services by sending the disabled children who in need of medical help to the hospitals. Twenty four per cent had mentioned Primary Health Centre located in their area. Ten per cent had mentioned specialist and by three per cent indicated special Institution.

It is disheartining to see that the Anganwadi Workers were not aware of the integrated education for

the disabled children which is being given importance. Now in order to bring them into the main stream.

(vi) Educational Facilities Availablefor the Disabled Children

Table XIV pictures the knowledge of Anganwadi workers in educational facilities available for the disabled children.

TABLE XIV

EDUCATIONAL FACILITIES AVAILABLE FOR THE DISABLED CHILDREN

S,No	Educational Facilities	No.of AWWs N=300 %
1	Visual Impaired	33
2	Speech Disorder	32
3	Hearing Impaired	25
4	Motor Disability	18
5	Mentally Retarded	13

Asreported by the Anganwadi workers, the minority of them were aware of educational facilities provided to the blind (33%) speech defective children (32%) and hearing impaired (25%) Motor disabled and mentally retarded were indicated by less than 20 per cent of the Anganwadi workers.

D. Involvement of the Parents and the Role of Society in the Care of the Disabled Children

This section features the importance of involvement of parents, guidance given by the Anganwadi Workers and role of the society in the care of the disabled children.

(i) Involvement of Parents in the care of the Disabled Children:

Table XV highlights the involvement of parents in the care of the disabled childrens expressed by the Anganwadi Workers.

TABLE XV

INVOLVEMENT OF PARENTS IN THE CARE OF THE DISABLED CHILDREN

S.No	Involvement of Parents	No.of AWWs N=300 %
1	Providing love and affection	63
2	Not considered as burden	56
3	Equal importance like normal child	53
4	Educating the disabled children	50
5	No answer	28

Importance of providing love and affection by the parents is realised by 63 per cent of the Anganwadi workers. Parents should not consider their disabled children as burden (56%) and they should be given equal importance as normal children (53%) were felt by the Anganswadi workers. Nearly half the selected Anganwadi workers had expressed that the disabled children should be given proper education.

Educating the disabled children can be best done only when parents and professionals work together. Parents are the best educators and only if they co-operate and involve themselves in the education programme they can help their children to develop (Gillian, 1979).

The Anganwadi workers had expressed that they contact the parents of the disabled children weekly once (57%0), once in fortnight (23%) and monthly once (10%).

ii. Area of Guidance

Table XVI focusses the area of guidance given by the Anganwadi workers to the parents of the disabled children.

TABLE XVI

AREA OF GUIDABCE GIVEN BY THE ANGANWADI WORKERS

S.No	Area	No.of AWWs N=300 %
1	Rearing Method	65
2	Nutrition	43
3	Early stimulation	31
4	Referral Services	29

Anganwadi Workers help the parents to understand the need for specific methods followed in rearing the disabled children (65%), imoportance of nutritious food for their growth and development (43%), need for early stimulation (31%0 and available referral services for their treatment.

(iii) Training Given to the Parents:

The Anganwadi workers informed that it is very difficult to give the special training for the parents of the disabled. Because they themselves find no time and further they had no special training in the assessment and care of the disabled children.

(iv) Role of Society in Helping the Disabled Children:

Table XVII shows the role of society in helping the disabled children.

TABLE XVII

ROLE OF SOCIETY IN HELPING THE DISABLED CHILDREN

S.No	Role of Society	No.of AWWS N=300 %
1	Treat like normal children	58
2	Preference in providing employment opportunity	55
3	Change the attitudes of people towards the disabled children	50
4	Provide special education	47
5	Provide proper medical services	42

Fifty eight per cent of the Anganwadi workers had expressed that society should treat the disabled children like normal children without any discrimination. More facilities for employment

opportunities should be created by the society was felt by 55 per cent of the Anganwadi workers followed by the change in the attitude of the people towards the disabled providing special education (47%) and medical services (42%) for the disabled.

E. Government Programmes for Rehabilitation of the Disabled:

Table XVIII highlights the government programmes for rehabilitation of the disabled known to the Anganwadi workers.

TABLE XVIII

GOVERNMENT PROGRAMMES FOR REHABILITATION OF THE DISABLED

S.No	Government Programmes	No.of AWWs N=300 %
1	Provide loans	56
2	Vocational Training	54
3	Concession to travel	54
4	Employment Opportunity	53
5	Educational Opportunity	49
6	Special Awards	43
7	Scholarships	39
8	Free medical facility	38
9	Financial support	30

It is clear from the above table that only half the number of selected Anganwadi Workers were aware of the governmental programmes for the disabled. Providing loans, giving vocational training, concession for travel, opportunity for employment were indicated by just more than 50 per cent of the Anganwadi workers. Educational opportunity and special awards were mentioned by 49 and 43 per cent of the Anganwadi workers respectively. Less than 40 per cent of them had mentioned scholarship, free medical facility and financial support.

(ii) Future Plan of the Anganwadi Workers:

The Anganwadi workers opined that they intended to give vocational training like basket making (25%), Doll making (21%) mat weaving (11%) and soap manufacturing (8%). They plan to give these vocational training to all kinds of disabled in their community.

Summary and Conclusion

V SUMMARY AND CONCLUSION

This study on "Role Perception of Anganwadi Workers Towards the Disabled Children" was conducted with 300 Anganwadi workers in Coimbatore city. The questionnaire was used to assess the role perception of anganwadi workers towards the disabled children.

Background of Anganwadi Workers:

1) More than 75 per cent of the Anganwadi workers had studied upto S.S.L.C. Only 15 per cent of them had completed higher secondary education and 1 per cent is coming under the graduate group.

2) The experience of the Anganwadi workers, ranged from less than 2 years to 11 years and above. Nine per cent of the teachers had gained the experience of less than two years. Those who had three to five years of experience were six per cent. Fifteen per cent of them had gained six to eight years of experience as Anganwadi workers. Sixty eight per cent of the Anganwadi workers had put in nine to eleven years of experience. Only two per cent of them had twelve years and above.

3) Out of 300 Anganwadi workers nearly 94 per cent of them were trained and the rest were untrained. Those who had undergone orientation training for 3 months is 91 per cent and the workers who had undergone refresher training of 15 and 10 days are 6 per cent and 3 per cent respectively.

Other findings of the study are:

4) Seventy five per cent of the Anganwadi workers had the opinion that, the disability conditions occur due to the heredity. Fifty seven per cent indicated the reason as infectious disease, consuming drugs during pregnancy (46%), trauma (43%), Consanganious marriages (41%) and early and llate marriages (36%).

5) Out of 300 disabled children identified 48 per cent were motor disabled, 21 per cent mentally retarded, 21 per cent speech defectives, 5 per cent multiple handicaps, three per cent blind and 2 per cent hearing impaired.

6) Sixty one per cent of the Anganwadi workers reported that they admitted the disabled children in their anganwadies while the rest did not.

7) The Anganwadi workers identified disabled children from their physical appearance, lack of co-ordination in their movement, voice disorders, hand and leg paralysis, failure to understand and repeat the speech, use of gestures for communication, leglimbing, delayed speech and language development and lack of concentration.

8) The additional facilities needed to identify the disabled children as expressed by the Anganwadi workers were special equipment (48%) finance (37%) and medical services (36%).

9) The type of attention given by the anganwadi workers for different type of disabilities are as follows: The mentally retarded children were given attention by teaching them by repetitions (51%), satisfying their basic needs (18%), and training them to meet daily needs (18%). For the blind sense training (38%) and mobility training (17%)were given. The hearing impaired were taught sign language (64%) Speech training (42%) and lip reading (41%) were given to speech defective children. In the case of motor disability, mobility training (27%) and training for the meeting the every day needs (11%) were given.

10) The methods used by the Anganwadi workers in the prevention of disabilities among children were immunisation for pregnant women and children, nutritious food for children, pregnant women and lactating mothers, medical check up for pregnant women, health checkup for children, taking of vitamin A and iron rich tablets, avoiding unnecessary drugs during pregnancy, avoiding marriage between close relatives, early and late marriages and also the x-rays during the pregnancy. Immunization was given prime importance by the Anganwadi workers.

11) Sixty three per cent of the Anganwadi workers were doing the referral service by sending the children to the hospitals, primary health centre (24%) specialist (10%) and to the special institution (37%).

12) Very less number of Anganwadi workers were known the available educational facilities for visually impaired (33%) speech disorder (32%), hearing impaired (25%) motor disability (18%) and mental retardation (13%).

13) A maximum percentage of the Anganwadi workers (63%) had expressed that the involvement of the

parents in the care of disabled children in terms of providing love and affection, not considering the disabled children as a burden giving equal importance like normal children and educating the disabled children.

14) The areas of guidance given by the Anganwadi workers to the parents of the disabled children were the rearing method (65%), nutrition (43%), early stimulation (33%) and referral services (29%).

15) Fifty eight per centage of the Anganwadi workers expressed, the society should treat the disabled children like normal ones. The similar percentage of the Anganwadi workers wanted the provision of employment opportunity, special education, proper medical service and change in attitude of the people towards the disabled children.

16) The various government programmes known to the Anganwadi workers for the rehabilitation of disabled were the provision of loans (56%), vocational training (54%), concession to travel (54%), employment opportunity (53%) and

educational opportunity (49%), special awards (43%), scholarships (39%), free medical facilities (38%) and financial support (30%).

17) The Anganwadi workers plan to give vocational training to all kinds of disabled in their community. Twenty five per cent basket making, doll making (21%) mat weaving (11%) and soap manufacturing (8%).

RECOMMENDATIONS

1) More attention should be given in the referral services provided for the pregnant women and the children.

2) The Anganwadi workers should be given training for the early detection of disabilities. Such orientation training can be organised at block level with the help of primary health centre staff.

3) It is the family and community which can provide the disabled child with emotional support and thus to integrate him with the society. In view of this, adequate emphasis should be given for parents and community education.

4) It is also important to orient the supervisors of the anganwadi workers. The other officers in the hierarchy, like child development, Project Officer and Senior State Level Officials, also need to be sensitized.

5) The training in early detection and prevention of childhood disabilities should be practical and field based. It should aim at inculcating skills for identifying impairments. The training should also be supplemented with adequate reading material like manuals handbooks etc.

6) Finally a proper recording system will have to be evolved so that the worker could follow up a child identified by her as having some impairment.

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Appendix

ஊனமுற்றவர்களைப் பற்றிய அறிவும் அங்கன்வாடி ஊழியர்களின் பங்கும் பற்றி அறிந்து கொள்ளுதல்

பதிவு எண் :
தேதி :

அங்கன்வாடி ஊழியரைப் பற்றி விபரம் :

அ. அங்க்ன்வாடி ஊழியரின் பெயர் :

ஆ. அங்கன்வாடி முகவரி :

இ. வயது :

ஈ. மதம் :

உ. கல்வித் தகுதி :

ஆரம்பப்பள்ளி :

உயர்நிலைப்பள்ளி :

மேல்நிலைப்பள்ளி :

கல்லூரி :

ஊ. எந்த வருடம் பணியில் சேர்ந்தீர்கள் :

எ. வேலை அனுபவம் :

ஏ. தாங்கள் அங்கன்வாடி ஊழியர்களுக்கான பயிற்சி பெற்றுள்ளீர்களா? : ஆம் / இல்லை

ஐ. பயிற்சி காலம் :

ஒ. பயிற்சி அளிக்கப்பட்ட இடம் :

ஓ. பயிற்சி அளித்த நிலையத்தின் முகவரி :

அங்கன் வாடி ஊழியரின் பங்கு :

1. உங்களுடைய பகுதியில் ஊனமுற்ற குழந்தைகள் இருக்கின்றார்களா?

ஆம் ( ) இல்லை ( )

ஆம் எனில் ஊனத்தின் வகைகள் யாவை ?

பகுதி/இடம்	பெயர்	ஊன வகை	வயது	இனம் ஆண்	இனம் பெண்
அங்கன் வாடிப்பள்ளி ( ) அங்கன்வாடிப் பகுதி ( )					

2. உங்கள் அங்கன் வாடி பகுதியில் உள்ள பள்ளிகளில் ஊனமுற்ற குழந்தைகளை இதுவரை சேர்த்து உள்ளீர்களா?

ஆம் ( ) இல்லை ( )

இல்லை எனில் காரணம் :

3. உங்கள் அங்கன் வாடியில் குழந்தைகளின் ஊனத்தை நீங்கள் எப்படி கண்டு பிடித்தீர்கள்?

ஊனமுற்ற வகைகள்	கண்டுபிடித்த விதம்

4. உங்கள் அங்கன்வாடியில் ஊனமுற்ற குழந்தைகளின் நிலை என்ன?

5. உங்கள் அங்கன்வாடியில் குழந்தைகளின் ஊனத்தை கண்டுபிடித்து, தன்னிறைவு பயிற்சியை பெற இன்னும் எவ்வகை வசதிகளை நீங்கள் எதிர்பார்க்கின்றீர்கள்?

6. நீங்கள் கீழ்க்கண்டவர்களுக்கு எவ்வகையான கவனிப்பை தருகிறீர்கள்?

ஊன வகைகள்	கவனிப்பு தரும் விதம்
மூளை வளர்ச்சிக் குன்றியவர்கள்	
பார்வை கோளாறு உள்ளவர்கள்	
காது கேளாதவர்கள்	
பேச்சு கோளாறு உள்ளவர்கள்	
கை, கால் ஊனமுற்றவர்கள்	

7. உங்கள் அங்கன்வாடி பகுதியில் ஊமை ஏற்படுவதைத் தடுக்கக் கூடிய பாதுகாப்பு நடவடிக்கைகள் மேற்கொள்கிறீர்களா?

ஆம் ( ) இல்லை ( )

ஆம் எனில், மேற்கொள்ளும் பாதுகாப்பு நடவடிக்கைகள்.

8. நீங்கள் ஊனமுற்ற குழந்தைகளை எப்போதாவது கீழ்க்கண்ட இடத்திற்கு அனுப்பியது உண்டா?

இடம்	ஆம்	இல்லை
ஆரம்ப சுகாதார மையம்		
மருத்துவமனை		
சிறப்பு மருத்துவர்		
சிறப்பு நிலையம்		
ஊனமுற்றோர்களுக்கான ஒருங்கிணைந்த கல்வித்திட்டம்		

9. ஊனமுற்றவர்களுக்கு உள்ள கல்வி வசதிகள் என்ன என்பதைப் பற்றி உங்களுக்குத் தெரிந்தவற்றைக் குறிப்பிடுக ?

10. ஊனமுற்ற குழந்தைகளுக்கு உதவி செய்வதில் குடும்பத்தினருடைய பங்கு பற்றி உங்கள் கருத்து யாது?

11. நீங்கள் ஊனமுற்ற குழந்தைகளின் வீட்டிற்குச் சென்று பெற்றோர்களிடம் குழந்தைகளின் பிரச்சனைகளைப் பற்றி பேசுகிறீர்களா?

ஆம்	இல்லை	எத்தனை நாட்களுக்கு ஒரு முறை	கொடுத்தது யோசனை

12. நீங்கள் ஊனமுற்ற குழந்தைகளின் பெற்றோர்களுக்கு சிறப்பு பயிற்சி அளிக்கிறீர்களா?

ஆம்	இல்லை	ஊனவகைகள்	பயிற்சி முறைகள்	பயன்கள்

13. ஊனமுற்ற குழந்தைகளுக்கு உதவி செய்வதில் சமுதாயத்தின் பங்கு பற்றி உங்கள் கருத்து யாது?

14. உங்களுக்கு ஊனமுற்றவர்களின் மறுவாழ்விற்காக அரசாங்கம் செய்யும் சேவைகள் பற்றி தெரியுமா ?

ஆம் ( ) இல்லை ( )

ஆம் எனில் அரசாங்கம் செய்யும் சேவைகள் பற்றிக் குறிப்பிடவும்.

15. ஊனமுற்றவர்களை பராமரித்து புனர் வாழ்வு கொடுக்க நீங்கள் என்ன செய்ய திட்டமிட்டுள்ளீர்கள்.

ஊன வகைகள்	அளிக்கப் போகும் மறுவாழ்வு பணி	உங்களுடைய பங்கு

ROLE PERCEPTION OF ANGANWADI WORKERS TOWARDS THE DISABLED CHILDREN

Background of Anganwadi Workers:

1. Name of the Anganwadi Worker

2. Anganwadi Address

3. Religion

4. Age

5. Qualification

   Middle School

   High School

   Higher Secondary School

   College

6. Year of Joining Duty

7. Period of Service

8. Have you undergone any training for teaching the disabled children

   YES NO

9. Duration of Training

10. Place of Training

11. Address of the Training Institute

Role Perception of Anganwadi Workers:

1. Have you come across disabled children in the Anganwadi ?

YES NO

If Yes, what kind of disability ?

Place	Names	Types of Disability	Age	Sex Male	Female
Anganwadi School ( )					
Anganwadi Place					

2. Do you admit the disabled children in your Anganwadi?

YES NO

If No, give reason?

3. How do you identify disabilities in children?

Types of Disability	Method of Identification

4. What is the condition of the disabled children in your Anganwadi ?

5. What other facilities do you need in Anganwadi for detection of the disabled children ?

6. What type of attention do you give for disabled Children ?

S.NO	TYpes of Disability	Types of attention
1	Mentally retardation	
2	Visual Impaired	
3	Hearing Disability	
4	Speech disorder	
5	Motor Disability	

7. Are you undertaking any measures for the prevention of disabilities in your Anganwadi

YES NO

If yes, mention,

8. Have you ever referred the disabled children in the following place :

+

Place	Yes	No
Primary Health Centre		
Hospital		
Specialist		
Special Institution		
Integrated Education for Disabled Vhildren		

9. What are the educational facilities available for the disabled children?

10. What do you thank about family's contribution towards the betterment of the disabled children ?

11. Do you pay visits to the disabled childrens houses and talk to their parents about their children's Problem ?

YES	NO	FREQUENCY	SUGGESTION GIVEN

+

12. Do you give special training to the parents of the disabled Children?

Yes	No	Types of Disability	Method iof training	Uses

13. What do you think of society's role in helping the disabled children?

14. Are you aware of the rehabilitation services available foir the disabled children?

YES NO

If yes, name some rehabilitation service

15. What are your future plans regarding the rehabilitation measures for the disabled children and your in it?

Types of Disability	Types of Rehabilitation Service	Role